



**Medi-Cal In-Home Operations Section
Home and Community-Based Services (HCBS) Branch
Manual Plan of Treatment (POT)**

1. BENEFICIARY INFORMATION

Name: _____ CIN: _____ DOB: _____ M ☐ F ☐
Last First

Address: _____ Phone #: () _____

City State Zip code

Medical Record #: _____ Primary Caregiver: _____

(Applicable for providers who use Medical Record #'s) Relationship to Beneficiary: _____

Primary Language: _____

2. PROVIDER INFORMATION

Name: _____ Title: _____

Address: _____ Phone #: () _____

City State Zip code

Provider #: _____ Fax #: () _____

Start of Care Date: _____ *Treatment Period: _____
(May cover up to 180 days maximum) FROM TO

3. PRIMARY CARE PHYSICIAN

Name: _____

Address: _____ Phone #: () _____

City State Zip code

Fax #: () _____

***Note: The treatment period may be less than the 180 days depending upon the licensure or certification requirements of the rendering provider.**

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**4. MEDICAL INFORMATION – Include ICD-9 Codes where appropriate.
Please add additional pages as needed.**

Primary Diagnosis	_____ ICD-9	Date of onset: _____
Secondary Diagnosis	_____ ICD-9	Date of onset: _____
Other Diagnosis	_____ ICD-9	Date of onset: _____
Other Diagnosis	_____ ICD-9	Date of onset: _____

Prognosis: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

**5. MEDI-CAL HOME AND COMMUNITY-BASED PROGRAM
Please check all that apply.**

- ☐ Nursing Facility (NF) In-Home Operations (IHO) Waiver ☐ NF Acute Hospital (A/H) Waiver
- ☐ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Private Duty Nursing ☐ Pediatric Day Health Care (PDHC)

**6. LEVEL OF CARE (LOC)
Please check only one.**

NOTE: The LOC determination will be made by the Medi-Cal In-Home Operations Section and provided to the HCBS provider once determined.

- | | | |
|--------------------------------|--|---|
| <input type="checkbox"/> Acute | <input type="checkbox"/> Adult Subacute | <input type="checkbox"/> Pediatric Subacute ventilator dependent |
| <input type="checkbox"/> NF-B | <input type="checkbox"/> NF-B Distinct Part (DP) | <input type="checkbox"/> Pediatric Subacute, non-ventilator dependent |
| <input type="checkbox"/> NF-A | <input type="checkbox"/> ICF-DDN | <input type="checkbox"/> ICF-DDH |

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7. WAIVER SPECIFIC SERVICES
Please check all that apply and enter the appropriate Frequency Key Code.
(Only complete if enrolled in a HCBS Waiver program.)

Service

Frequency Key Code:

D=Daily W=Weekly
Y=Yearly M=Monthly
O=Other

**If other,
please describe below.**

<input type="checkbox"/> Case Management	_____	_____
<input type="checkbox"/> Transitional Case Management	_____	_____
<input type="checkbox"/> Private Duty Nursing Care <input type="checkbox"/> Individual <input type="checkbox"/> Shared	_____	_____
<input type="checkbox"/> Family Training	_____	_____
<input type="checkbox"/> Certified Home Health Aide Services	_____	_____
<input type="checkbox"/> Waiver Personal Care Services	_____	_____
<input type="checkbox"/> Respite <input type="checkbox"/> Home <input type="checkbox"/> Facility	_____	_____
<input type="checkbox"/> Medical Equipment Operating Expenses	_____	_____
<input type="checkbox"/> Environmental Accessibility Adaptations	_____	_____
<input type="checkbox"/> Personal Emergency Response System	_____	_____
<input type="checkbox"/> Community Transition Services	_____	_____
<input type="checkbox"/> Habilitation Services	_____	_____

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8. NONWAIVER SERVICES

Include all applicable services and frequency. May include those services funded by Medi-Cal, Regional Centers, California Children's Services, Independent Living Centers, In-Home Supportive Services, Department of Rehabilitation, Department of Mental Health, Private Insurance, and/or school-based services.

Examples include: Adult Day Health Care, Pediatric Day Health Care, Medical Therapy Program, Housing Referrals, Social Service Referrals, and Vocational Rehabilitation. Please add additional pages as needed.

9. MEDICATION PLAN FOR HOME PROGRAM

Space for additional medications provided on Page 5.

Allergies: _____ Reaction (if known): _____

Who gives the medications to the patient? _____

Medication: _____ Dose: _____ Route: _____ Frequency: _____

Medication: _____ Dose: _____ Route: _____ Frequency: _____

Medication: _____ Dose: _____ Route: _____ Frequency: _____

Medication: _____ Dose: _____ Route: _____ Frequency: _____

Medication: _____ Dose: _____ Route: _____ Frequency: _____

Medication: _____ Dose: _____ Route: _____ Frequency: _____

Medication: _____ Dose: _____ Route: _____ Frequency: _____

Medication: _____ Dose: _____ Route: _____ Frequency: _____

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Please include type of diet, and method, amount, and frequency of feeding.

- 11. TREATMENT PLAN FOR HOME PROGRAM**
Include all needed services, frequency, and duration of services and provider(s) of service(s).
Space for additional orders provided on Page 7.

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11a.

**TREATMENT PLAN FOR HOME PROGRAM – CONTINUED
ADDENDUM**

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12. FUNCTIONAL LIMITATIONS
Please describe functional limitations per the physician's order within each category.
Please add additional pages as needed.

☐ No limitations noted.

MOTOR: May include limitations with walking and/or gross motor movement.

☐ No limitations noted.

SELF HELP: May include limitations with activities of daily living such as bathing, toileting, eating, and dressing.

☐ No limitations noted.

COMMUNICATION/SENSORY: May include limitations with hearing, speech, and sight.

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13. ACTIVITIES
Include permitted activities per the physician's order, such as up with assistance, complete bedrest, up as tolerated, use of adaptive equipment such as wheelchair, walker, etc.

☐ No restrictions on activities.

Safety precautions in use:
Rehabilitation Potential:

☐ Seizure precautions
☐ Good

☐ Universal precautions
☐ Fair

☐ Other:
☐ Poor

14. MENTAL STATUS
May include information related to behavior and/or cognition such as aggression, depression, agitation, confusion, and developmental disabilities.

☐ No limitations noted – oriented to name, date, place, and time.

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15. DURABLE MEDICAL EQUIPMENT
Include all types of equipment used, providers of equipment, and funding sources (if known).

TYPE	PROVIDER NAME	FUNDING SOURCE

16. MEDICAL SUPPLIES
Include all types of supplies used, providers of supplies, and funding sources (if known).

TYPE	PROVIDER NAME	FUNDING SOURCE

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17.	THERAPIES/REFERRALS
Check all that apply. Please include the date the referral was made and the reason why. If therapy is ongoing, please indicate the current progress/status in Section 20.	

<input type="checkbox"/> Physical Therapy	<hr style="border: none; border-top: 1px solid black;"/>	<hr style="border: none; border-top: 1px solid black;"/>
	Date	Referral Reason
<input type="checkbox"/> Occupational Therapy	<hr style="border: none; border-top: 1px solid black;"/>	<hr style="border: none; border-top: 1px solid black;"/>
	Date	Referral Reason
<input type="checkbox"/> Speech Therapy	<hr style="border: none; border-top: 1px solid black;"/>	<hr style="border: none; border-top: 1px solid black;"/>
	Date	Referral Reason
<input type="checkbox"/> Enterostomal Therapy	<hr style="border: none; border-top: 1px solid black;"/>	<hr style="border: none; border-top: 1px solid black;"/>
	Date	Referral Reason
<input type="checkbox"/> Medical Social Worker	<hr style="border: none; border-top: 1px solid black;"/>	<hr style="border: none; border-top: 1px solid black;"/>
	Date	Referral Reason
<input type="checkbox"/> Nutritionist	<hr style="border: none; border-top: 1px solid black;"/>	<hr style="border: none; border-top: 1px solid black;"/>
	Date	Referral Reason
<input type="checkbox"/> Other/List	<hr style="border: none; border-top: 1px solid black;"/>	<hr style="border: none; border-top: 1px solid black;"/>
	Date	Referral Reason
<input type="checkbox"/> Other/List	<hr style="border: none; border-top: 1px solid black;"/>	<hr style="border: none; border-top: 1px solid black;"/>
	Date	Referral Reason

18.	TREATMENT GOALS/DISCHARGE PLAN
Please check only one.	

- ☐ Upon completion of treatment plan, the beneficiary will be able to function independently and maintain self safely in the home setting.
- ☐ Upon completion of this treatment plan, the beneficiary will continue to need
☐ Minimal ☐ Moderate ☐ Maximum support to be maintained safely in the home setting.
- Describe specific goals and discharge plan, as related to the identified needs:

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19. TRAINING NEEDS FOR BENEFICIARY/FAMILY

- ☐ No training needs have been identified for the beneficiary and/or the family during this treatment period.
- ☐ Yes, there are training needs for the beneficiary and/or the family during this treatment period.

(If the yes box is checked, please describe the training needs and name(s) of the provider(s).)

Please use additional pages as needed.

20. SUMMARY OF BENEFICIARY STATUS DURING THIS TREATMENT PERIOD

Please use additional pages as needed.

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21. After completing, please print and obtain original signatures. Keep the original and mail a copy to the attention of the appropriate IHO Regional Office and the Medi-Cal In-Home Operations assigned Nurse Case Manager.

Beneficiary Signature

Date

Primary Caregiver Signature (as applicable)

Date

Physician Signature

Date

Provider Signature

Date

Provider Signature

Date

Provider Signature

Date

Provider Signature

Date

Provider Signature

Date

Provider Signature

Date

Provider Signature

Date

Provider Signature

Date